

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-011768**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 382

Primary Registration District No. 5655

Registrar's No. 174

**FILED MAR 21 1962**

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Vernon</b>		c. CITY OR TOWN <b>Republic</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Sanatorium</b>		d. STREET ADDRESS <b>Route 1</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Joreece Louise Leonard</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-1918</b>
9. AGE (last birthday) <b>43</b>		IF UNDER 1 YEAR Months <b>43</b> Days <b>43</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (City and state or country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>	
13a. FATHER'S NAME <b>John Boring</b>		13b. MOTHER'S MAIDEN NAME <b>Minnie Wright</b>	
14. NAME OF HUSBAND OR WIFE <b>Carmel</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT <b>Hospital Records, Mo. S. S., Mt. Vernon, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary fibrosis</b>		<b>2-3 years</b>	
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Recurrent spontaneous pneumothoraces</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>3-3-62</b> Month, Day, Year a.m. <b>5:00 a.m.</b> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Mo. S. S., Mt. Vernon, Mo.</b>
21. I attended the deceased from <b>3-3-62</b> to <b>3-9-62</b> and last saw her alive on <b>3-9-62</b> Death occurred at <b>5:00 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD</b>	
22b. ADDRESS <b>Mo. S. S., Mt. Vernon, Mo.</b>		22c. DATE SIGNED <b>3-9-62</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	23b. DATE <b>3-10-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
24. FUNERAL DIRECTOR <b>W.B. Cantrell Republic, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-15-62</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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**133-0**

MAR 22 1962  
MAR 19 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William B. Centell

Licensed Embalmer No. 4830

P. O. Address Republic, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.